PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D35

PROVIDER–
QRS 2006 Outlier Reconciliation Group
(Attachment A)

Provider Nos.: 34-0091, 50-0044

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

RECORD HEARING DATE –
August 13, 2020

Fiscal Year Ending –
September 30, 2006
December 31, 2006

Case No. – 14-4410G

INDEX

ISSUE STATEMENT

Whether the Centers for Medicare and Medicaid Services ("CMS") was arbitrary and capricious in establishing a 10 percent threshold in 2003 and whether CMS was arbitrary and capricious in using the same 10 percent threshold in 2006 to determine whether Providers would be subject to outlier reconciliation adjustments for fiscal year ("FY") 2006?[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor was not arbitrary and capricious in using the 10 percent threshold in 2006 to determine whether the Providers would be subject to outlier reconciliation adjustments for FY 2006.

INTRODUCTION

QRS 2006 Outlier Reconciliation Group ("Providers") is an *optional* group consisting of two unrelated Medicare-certified acute care hospitals located in Guilford, North Carolina and Spokane, Washington.[2] The Providers' assigned Medicare contractor[3] is National Government Services, Inc. ("Medicare Contractor").

The Providers are disputing approximately $5,188,000 in outlier payments that were excluded from their respective FY 2006 cost reports due to the cost outlier threshold set by CMS. The Providers state, "CMS withheld 5.1% of DRG [diagnostic related group] payments from Providers to fund outlier payments. However, CMS failed to return 5.1% to hospitals."[4]

The Providers timely appealed the issue to the Board and met the jurisdictional requirements for a hearing. On October 8 and 18, 2019, the Providers requested a Record Hearing. On August 13, 2020, the Board granted the Providers' Request for a Record Hearing. The Providers were represented by Russel Kramer of Quality Reimbursement Services, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

A. REGULATORY BACKGROUND

42 U.S.C. § 1395ww(d) established an inpatient prospective payment system ("IPPS") for *operating* costs of acute care hospital stays under Medicare Part A. Under IPPS, each case is

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[1] Stipulations of the Parties at ¶ 1 (October 18, 2019) (hereinafter "Stipulations").
[2] Providers' Final Position Paper (hereinafter "Providers' FPP") at 2 (June 6, 2019).
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[4] Providers' FPP at 2.

categorized into a diagnostic-related group ("DRG"). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. In addition to the DRG payment, hospitals can receive several other adjustments or add-on payments, one of which is an operating outlier payment for particular cases that are unusually costly.[5]

Additionally, 42 U.S.C. § 1395ww(g) requires the Secretary to pay for the *capital* related costs of inpatient hospital services with a prospective payment system ("Capital PPS"). Under Capital PPS, payments are adjusted by the same DRG for the case, as they are under IPPS. Similarly, hospitals also receive, under Capital PPS, a capital outlier payment for those cases that qualify.[6]

To receive an outlier payment, the combined operating and capital cost of a case must exceed the fixed–loss outlier threshold amount ("a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers").[7] The operating cost and the capital cost of a case are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios ("CCRs").

The regulation at 42 C.F.R. § 412.84(h) provides the instructions for applying CCRs in outlier determinations. Prior to 2003, this regulation stated:

> The operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are *computed annually* by the intermediary for each hospital *based on the latest available* ***settled*** *cost report* for that hospital and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under § 412.8(b).[8]

On June 9, 2003, the Secretary published a final rule solely addressing cost outliers that was entitled "Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases ("Cost Outliers") Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems" (the "June 2003 Final Rule").[9] In the preamble to the June 2003 Final Rule, the Secretary explained that outlier payments made for discharges on or after October 1, 2003 are "subject to possible reconciliation" when hospitals' cost reports are settled and that hospitals are "on notice" of this change:[10]

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[5] 42 C.F.R. §§ 412.80 - 412.86.
[6] *Id.* § 412.312(c).
[7] 68 Fed. Reg. 34494, 34495 (June 9, 2003).
[8] (Emphasis added.)
[9] 68 Fed. Reg. at 34494.
[10] *Id.* at 34502 (implementing the regulations at issue).

> [I]n light of the gross abuses of the current methodology by some hospitals and the negative impact such overpayments ultimately have on other hospitals due to their effect on the threshold, we believe the option of *reconciling outlier payments based on the settled cost report for hospitals* that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. In our view, *reconciling outlier payments* because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate Medicare services upon medical or other review. This review is explicitly provided for at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785).
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> . . . [I]f we deem it necessary as a result of a hospital-specific data variance to reconcile outlier payments of an individual hospital, such action on our part would not affect the predictability of the entire system. Rather, because ***each hospital is on notice*** *as to our revised methodology* for determining cost-to-charge ratios ***and*** *that outlier payments are* ***subject to possible reconciliation***, and because each hospital has the necessary data regarding its own costs and charges to predict its actual cost-to-charge ratio, we are able to maintain the predictability of the system as a whole. Further, because reconciliation of outlier payments will affect only certain hospitals, the administrative burden of implementing such a policy is minimized.[11]

Accordingly, as part of the June 2003 Final Rule, the Secretary modified 42 C.F.R. § 412.84, in relevant part, to address CCRs applicable to outlier determinations on a going-forward basis in a new subsection (i). In pertinent part, this revised regulation states:

> (h) For discharges occurring ***before*** October 1, 2003, the operating and capital cost-to-charge ratios used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. For discharges occurring before August 8, 2003, statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of

[11] *Id.* (emphasis added).

> prospective payment rates published in the Federal Register in accordance with § 412.8(b).
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> (i)(1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.
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> (2) *For discharges occurring* ***on or after October 1, 2003***, the operating and capital cost-to-charge ratios applied at the time a claim is processed are *based on either the most recent* ***settled*** *cost report* ***or*** *the most recent* ***tentative settled*** *cost report, whichever is from the latest cost reporting period*.
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> (4) *For discharges occurring on or* ***after August 8, 2003***, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.[12]

Significantly, the new § 412.84(i)(4) allows for reconciliation and final settlement of outlier payments using actual CCRs based on the cost reporting period being settled.

Finally, as part of the June 2003 regulatory revisions, the Secretary implemented a "time value of money" adjustment because a hospital that receives *excess* outlier payments would have access to those funds until the amount was repaid to the Medicare trust funds (or in the case of an underpayment would not have had access to the appropriate amount of funds during the same period).[13] The Secretary gave the following explanation of why the "time value of money" adjustment is necessary:

> [O]utlier payments are uniquely susceptible to manipulation because hospitals set their own level of charges and are able to change their charges without notification to, or review by, their fiscal intermediary. Such changes by a hospital directly affect its level of outlier payments, unlike IME or DSH where the fiscal intermediary must agree to a change to the underlying data. Therefore, even though the money may be recouped if the outlier payments are reconciled, the hospital would essentially be able to unilaterally increase its charges and acquire an interest-free loan in

[12] *Id.* at 34515 (emphasis added).
[13] *Id.* at 34504.

> the meantime. *For that reason*, *we believe it is appropriate to apply an adjustment for the* ***time value*** *of overpayments or underpayments* identified at cost report reconciliation. Because the other changes we are making in this final rule will largely ensure the payments hospitals receive for outlier cases are accurate, we do not anticipate it will be necessary to apply this adjustment broadly. Therefore, the actual total impact of this adjustment should be relatively small.[14]

Further, in the preamble to the June 2003 Final Rule, the Secretary gave the following response to a comment questioning the authority of the Secretary to make the "time value of money" adjustment:

> [T]his adjustment is consistent with the statutory requirement at . . . [42 U.S.C. § 1395ww(d)(5)(A)(iii)] that outlier payments approximate the marginal cost of care beyond the threshold. That is, because hospitals are uniquely able to manipulate outlier payments by increasing charges, it is necessary to establish a mechanism whereby an adjustment can be made to ensure payments appropriately reflect the true marginal costs of care for outlier cases. As a result, the outlier adjustment can be distinguished from other IPPS payment adjustments where interest is applied, such as IME or DSH, because changes to these adjustments are subject to review by the fiscal intermediary before additional payments are made.[15]

Accordingly, the June 2003 Final Rule promulgated the time value of money adjustment at 42 C.F.R. § 412.84(m) which states:

> Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph (i)(4)[16] of this section, outlier payments *may be adjusted to account for* ***the time value*** *of any underpayments or overpayments*. Any adjustment will be based upon a widely available index to be established ***in advance*** by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.[17]

In adopting the CCR reconciliation process, the Secretary specified in the preamble to the June 2003 Final Rule that she would issue additional instructions on the threshold that would trigger mandatory reconciliation. The Secretary also confirmed that Medicare contractors have "administrative discretion" to perform reconciliation when an analysis "indicates the outlier payments made . . . are significantly inaccurate":

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[14] *Id.* (emphasis added).
[15] *Id*.
[16] The regulation originally cross-referenced paragraph (h)(3), but was amended to reference paragraph (i)(4) in 2006. *See id.*; 71 Fed. Reg. 47869, 48098, 48138 (Aug. 18, 2006).
[17] 68 Fed. Reg. at 34515 (emphasis added).

> In addition, most of the changes in this regulation will apply for approximately the last 2 months of FY 2003. We intend to limit the impact of this provision during FY 2003 to ensure that the limited resources of fiscal intermediaries are focused upon those hospitals that appear to have disproportionately benefited from the time lag in updating their cost-to-charge ratios and to maintain the overall predictability of FY 2003 payments for most hospitals. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003.
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> ***In the same program instruction***, *we will issue thresholds for fiscal intermediaries to reconcile outlier payments for other hospitals during FY 2003*.
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> For cost reporting periods beginning during FY 2004, we are *considering* instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be ***plus or minus 10 percentage points*** from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period. Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, *fiscal intermediaries would also have the* ***administrative discretion*** *to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate*.[18]

Consistent with the above preamble discussion, CMS issued Program Memorandum Intermediaries Transmittal ("PMIT") A-03-058 on July 3, 2003[19] to provide guidance to Medicare Contractors on the reconciliation process. PMIT A-03-058 finalized the 10 percent threshold discussed in the June 9, 2003 Final Rule, stating in pertinent part:

> [F]or discharges occurring in cost reporting periods beginning on or after October 1, 2003 for all other IPPS hospitals, fiscal intermediaries are to reconcile outlier payments at the time of cost report final settlement if:

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[18] *Id.* at 34503 (emphasis added).

[19] DHHS, CMS, Program Memorandum Intermediaries, Transmittal A-03-058, Change Req. 2785 (July 3, 2003) (copy at Exhibit C-3) (also *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03058.pdf (last visited Sept. 15, 2022). The instructions in this memorandum were later incorporated into MCPM, Ch. 3, § 20.2 (Rev. 707, Oct. 12, 2005) (hereinafter "PMIT A-03-058").

> 1) Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and
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> 2) Total outlier payments in that cost reporting period exceed $500,000.
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> Consistent with the June 9, 2003 **Federal Register** (68 FR 34504) in which we indicated that we intended to issue program instructions that would provide specific criteria for identifying those hospitals subject to reconciliation for the remainder of FY 2003 and for FY 2004, these criteria allow fiscal intermediaries to focus their limited resources on only those hospitals that appear to have disproportionately benefited from the time lag in updating their CCRs.
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> These criteria for IPPS . . . will be reevaluated periodically to assess whether they should be revised.
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> In the event that the criteria in this section III for IPPS hospitals . . . do not identify additional hospitals that are being similarly overpaid (or underpaid) significantly for outliers, then, based on an analysis of the hospital's most recent cost and charge data that indicates that CCRs for those hospitals are significantly inaccurate, fiscal intermediaries also have the administrative discretion to reconcile cost reports of those additional IPPS hospitals . . . . However, fiscal intermediaries must seek approval from their CMS Regional Office in the event they intend to reconcile outlier payments for an IPPS hospital . . . that does not meet the above-specified criteria.
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> CMS will be issuing separate instructions detailing procedures to follow regarding this reconciliation process and the application of the adjustment for the time value of money.[20]

On October 12, 2005, CMS issued Transmittal 707 for the Medicare Claims Processing Manual ("MCPM"), to "tell[] FIs how to implement the policies of IPPS reconciliation and how to apply the time value of money to reconciliation" under 42 C.F.R. § 412.84.[21] CMS essentially incorporated PMIT A-03-58 into the MCPM and added the following provisions at MCPM, Ch. 3, § 20.1.2.6 to address the adjustment for the time value of money:

> Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under § 20.1.2.5, outlier payment

[20] *Id.* at 4-5.
[21] MCPM, Transmittal 707, Change Req. 3966 at 1 (Oct. 12, 2005) (copy at Exhibit C-4).

> may be adjusted to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the hospital's cost reporting period being settled to the date on which the CMS Central Office receives notification from the FI that reconciliation should be performed.
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> *If a hospital's outlier payments have met the criteria for reconciliation, CMS will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of that adjustment*. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.
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> The following formula will be used to calculate the rate of the time value of money.
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> (Rate from Web site as of the midpoint of the cost report being settled / 365 or 366) * # of days from that midpoint until date of reconciliation.
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> For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the FI , or the date an email was received from the FI by the CMS Central Office, whichever date is first.[22]

B. THE PROVIDERS' NOTICES OF PROGRAM REIMBURSEMENT THAT ARE AT ISSUE

The Providers in this optional group appeal consists of the following two unrelated acute care hospitals whose FY 2006 cost reports received an outlier reconciliation prior to the issuance of each Provider's final Notice of Program Reimbursement ("NPR"):

1. The Moses H. Cone Memorial Hospital, Prov. No. 34-0091, whose FY 2006 ended on September 30, 2006; and

2. Deaconess Medical Center, Prov. No. 50-0044, whose FY 2006 ended on December 31, 2006.[23]

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[22] *Id*. at 21-22 (emphasis added).

[23] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 9 (July 30, 2019); *see also* Exhibit C-1.

The Providers were selected for outlier reconciliation in accordance with CMS' instructions in PMIT A-03-058. Per that PMIT, Medicare contractors are instructed to reconcile outlier payments at the time of cost report final settlement, if the providers' CCRs increased more than 10 percent between the CCRs used to pay the original claims and the CCRs used during the cost report settlement process and the total outlier payments were more than $500,000.[24] On August 14, 2012 and October 16, 2012, the Medicare Contractors issued the Providers' final NPRs for their FY 2006 cost reporting periods. The August 14, 2012 NPR for Deaconess Medical Center reduced its operating outlier payment by $1,882,636 and its capital outlier payment by $133,724. Similarly, the October 16, 2012 NPR for Moses H. Cone Memorial Hospital reduced its operating outlier payment by $2,381,821 and its capital outlier payment by $166,135. In addition, the Medicare Contractor assessed a "time value of money" adjustment for Moses H. Cone Memorial Hospital in the amount of $445,543 and for Deaconess Medical Center in the amount of $178,220.[25] The Providers contend that "the [10 percent] threshold criteria used to select [them] for outlier reconciliation was arbitrary, capricious and an abuse of the Secretary's discretion."[26]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

A. VALIDITY OF THE 10 PERCENT THRESHOLD FOR OUTLIER RECONCILIATION

The Providers assert "the Secretary's final determination of outlier payments for the federal fiscal years ["FFYs"] 2006 and 2007 was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. § 706(2)(A). . . ."[27] The Providers further argue that the Secretary should have taken into account relevant factors and data when setting the criteria, failed to consider alternative methodologies when establishing the outlier thresholds and failed to demonstrate a reasonable connection between the thresholds and the factors considered.[28] The Providers continue, stating, "[b]y ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled."[29] The Providers conclude that, "[a]s a result of these arbitrary and capricious actions, the thresholds were set too high, the resulting amount of outlier payments each year fell short of the percentage required by the Medicare Act and hospitals did not receive the amount of outlier payments that Congress intended."[30]

The Providers contend that "[t]he final rule dated June 9, 2003, was the product of notice and comment rulemaking. However, the 10% trigger for requiring reconciliation was not mandated by the final rule."[31] Specifically, the Providers maintain:

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[24] Medicare Contractor's FPP at 10-12.
[25] Stipulations at ¶¶ 4, 5, 9; Providers' Group Appeal Request, Ex. 1, Tab A, Tab B (Adj. No. 20) [time value of money total is the accumulation of 2 adjustments of $416,492 and $29,051, respectively], Ex. 2, Tab A, Tab B, Tab D (Adj. No. 28), Tab E [time value of money total is the accumulation of 2 amounts of $166,401 and $11,819, respectively] (September 25, 2014).
[26] Medicare Contractor's FPP at 9.
[27] Provider's FPP at 6.
[28] *Id.*
[29] *Id*. at 7.
[30] *Id*.
[31] *Id*. at 9.

> The final rule merely stated that the agency was "*considering"* applying a 10% fluctuation trigger for FY [fiscal year] 2004. . . . The 10% fluctuation threshold was not actually mandated until the issuance of PM[IT] A-03-058 on July 3, 2003. The 10% variation threshold would have been the product of notice and comment rulemaking had the agency provided the public with an opportunity to comment on it. However, this did not occur. The 10% threshold was not mentioned in the proposed rule dated March 5, 2003. Instead, the first mention of the possibility of employing a 10% threshold was in the *final rule* dated June 9, 2003. This final rule did not provide the public with an opportunity to comment on the agency's "*consideration*" of a 10% threshold. Accordingly, the 10% threshold was not the product of notice and comment rulemaking.[32]

The Providers continue arguing:

> [T]he 10% fluctuation for requiring reconciliation is an arbitrary figure that reflects the legislative quality of the agency rulemaking. . . . Under the principle announced in [the D.C. Circuit's decision in] *Catholic Health Initiatives*,[33] the agency may well have the right to mandate a bright line mathematical test. However, the essentially legislative quality of the agency's judgment mandates that such a bright line mathematical test be preceded by formal notice and comment rulemaking. Based on the reasoning of *Catholic Health Initiatives*, the 10% fluctuation trigger should be viewed as a legislative rule. . . . As such, the 10% limitation is invalid because the agency has never undertaken notice and comment rulemaking in connection with its adoption.[34]

The Providers contend that the 10 percent threshold reconciliation trigger was not the product of notice and comment rulemaking because the proposed rule, dated March 5, 2003, did not mention the 10 percent threshold, and "the final rule merely stated that the agency was '*considering'* applying a 10 percent fluctuation trigger for FY [fiscal year] 2004."[35] The Providers also reference the fact that the 10 percent threshold was "not actually mandated until the issuance of PM[IT] A-03-058 on July 3, 2003. . . ."[36] Relying on the D.C. Circuit Court's decision in *Catholic Health Initiatives*,[37] the Providers assert the principal that, although, "the agency may well have the right to mandate a bright line mathematical test . . . , the essentially legislative quality of the agency's judgment mandates that such a bright line mathematical test [*i.e*., the 10 percent reconciliation threshold] be preceded by formal notice and comment rulemaking."[38] The Providers conclude that, because CMS did not specifically enact the 10

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[32] *Id.*
[33] 617 F.3d 490, 495 (D.C. Cir. 2010).
[34] Provider's FPP at 10-11.
[35] *Id.* at 9.
[36] *Id.*
[37] 617 F.3d 490, 495 (D.C. Cir. 2010).
[38] Providers' FPP at 11.

percent reconciliation threshold through regulation, and did not provide the public with an opportunity to comment on PMIT A-03-058, the 10 percent reconciliation threshold does not meet the notice and comment requirement.[39]

The Providers also contend that the 10 percent reconciliation threshold also falls within the publication requirements of the Freedom of Information Act,[40] and that "[t]he failure of the agency to adhere to these publication requirements was therefore a violation of these statutory provisions."[41] This failure, according to the Providers, voids the 10 percent reconciliation threshold requirement.

The Providers assert that, because there is no indication that CMS has ever reevaluated the 10 percent threshold, "[t]he 10% criterion is therefore based upon outdated assumptions, such as the existence of inflation in outlier payments."[42] In support, the Providers contend that: (1) the 10 percent criterion may be based upon outdated figures because CMS has routinely fallen short of its 5.1 percent target figure in more recent cost periods; and (2) the Agency has failed in its obligation to annually reevaluate the 10 percent reconciliation threshold's continued validity, because the 10 percent figure has not changed for nearly a decade. Therefore, the Providers' argue that the 10 percent threshold should not be applied to post 2004 fiscal years, unless the Agency provides substantial evidence supporting the continued viability of the original assumptions upon which that figure was based.[43]

The Providers also contend that the Medicare Contractor miscalculated the time value of money when reconciling their outlier payments. The Providers claim that, per the regulation at 42 C.F.R. § 412.858(a)(4)(iv)(E), the time value of money should only be applied to the October 1, 2006 through December 31, 2006 discharges, not on all the high cost outlier cases during the entire 2006 cost reporting period.[44] The Providers also contend that the Medicare inpatient cost to charge ratio ("CCR") is in error and needs to be revised to correct the errors made and contained in the cost report. The corrections to the CCR will have an impact on the outlier amount due the Provider, as determined in the reconciliation process.[45]

The Medicare Contractor asserts that the Providers bear the burden of proof for each of their arguments and that several of the Providers' allegations are blanket assertions with no supporting facts. In fact, the Medicare Contractor points out that, after making a blanket assertion, many of the Providers' allegations are never discussed again. The Medicare Contractor believes that these arguments, unsupported by fact or law, should not be considered by the Board.[46]
The Medicare Contractor points out that CMS agreed with one public commenter to the March 5, 2003 Outlier Correction Proposed Rule who requested that parameters be established to identify what hospitals would be subject to reconciliation (*i.e.*, a change of +/-15 percent in the CCR used to calculate the claim and the finalized cost report). Specifically, CMS stated:

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[39] *Id.*
[40] 5 U.S.C. § 552(a) and/or 42 U.S.C. § 1395hh(c).
[41] Providers' FPP at 11.
[42] *Id*. at 12.
[43] *Id.* at 12-13.
[44] *Id.* at 13.
[45] *Id.*
[46] Medicare Contractor's FPP at 4.

> For cost reporting periods beginning during FY 2004, we are considering instructing fiscal intermediaries to conduct reconciliation[s] for hospitals whose actual cost-to-charge ratios are found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000.[47]

CMS recognized that it would be impossible for Medicare Contractors to reconcile every hospital's outlier payments and that setting thresholds would focus their resources on those hospitals that were potentially still gaming the system.[48]

The Medicare Contractor explained that, on July 3, 2003, CMS issued PMIT A-03-058 to assist Fiscal Intermediaries with implementation of the new outlier procedures and included thresholds which triggered reconciliation of a hospital's outlier payments during FY 2003. PMIT A-03-058 also outlined the use of more recent data for determining CCRs and the thresholds for which hospitals with discharges after October 1, 2003 would be susceptible to outlier reconciliation.[49] The Medicare Contractor notes that the terms of Transmittal 707, dated October 12, 2005,[50] is applicable to the fiscal years under appeal here and that the thresholds did not change between the FFY 2003 Final Rule, PMIT A-03-058 or Transmittal 707.[51]

The Medicare Contractor argues that "the reconciliation thresholds outlined in the final rule and these transmittals were logical outgrowths of the Commenter's request to establish thresholds and were therefore, not in violation of the APA or the Freedom of Information Act (FOIA)."[52] The Medicare Contractor further maintains that the Providers involved in this appeal "were selected for outlier reconciliation because their CCRs increased more than 10% between the CCRs used to pay the original claims and the CCRs used during the cost report settlement process and the total outlier payments were more than $500,000."[53]

As support for its position, the Medicare Contractor points to the D.C. Circuit's decision in *Clarian Health West, LLC v. Hargan* ("*Clarian*"),[54] stating "the D.C. Circuit . . . [f]ollowing a full review of the APA's requirements and situations in which those requirements applied, . . . determined that the 2003 rule (which governed reconciliations for turbocharging) followed notice and comment and, therefore complied with the APA."[55] The Medicare Contractor continues, stating that the D.C. Circuit concluded, after examining the Medicare Claims Processing Manual (CMS Manual, Ch. 3 § 20.1.2.5, J.A. 129-30) and discussing the applicable standards for determining whether a rule or regulation required notice and comment, that the Manual "merely

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[47] 68 Fed. Reg. at 34503.
[48] Medicare Contractor's FPP at 9-10.
[49] *Id.* at 10.
[50] Exhibit C-4.
[51] Medicare Contractor's FPP at 11.
[52] *Id.*
[53] *Id.* at 11-12.
[54] *Clarian Health West, LLC v. Hargan,* 878 F.3d 346, 351 (D.C. Cir. 2017). *See also* Exhibit C-5.
[55] Medicare Contractor's FPP at 12-13.

explain[s] how the agency will enforce a statute or regulation – in other words, how it will exercise its broad enforcement discretion."[56] Accordingly, the Medicare Contractor argues that the rules governing the reconciliation process: (1) were discussed in depth (twenty-two pages of discussion) in the FY 2003 final rule; (2) PMIT A-03-058 was the outgrowth of the 2003 final rule; (3) Transmittal 707 did not change the thresholds established in PMIT A-03-058; and, (4) the Medicare Claims Processing Manual simply explained how CMS would exercise its authority with regard to reconciliation of outlier payments. The Medicare Contractor concludes that, "[b]ecause the procedures are rationally related to the goals of outlier reconciliation, the procedures are neither arbitrary nor capricious. . . ." and that the "Providers have failed to support their arbitrary and capricious claims with evidence or law and have fully failed to satisfy their burden of proof."[57]

The Medicare Contractor requests that the Board not consider the Providers' arguments on the Time Value of Money, as the Time Value of Money was not originally appealed and is outside the scope of this appeal. Finally, the Medicare Contractor asks the Board to uphold its outlier reconciliation conclusions.[58]

At the outset, the Board notes it is important to first understand the Medicare regulations and rules for the payment of outliers that were in effect during the time at issue — FY 2006. The preamble to the June 2003 Final Rule specifies that outlier payments, made for discharges on or after October 1, 2003, are "subject to possible reconciliation" when hospitals' cost reports are settled and that hospitals are "on notice" of this change.[59] The Secretary's *discretionary* authority to make such reconciliations is specified at 42 C.F.R. § 412.84(i)(4) (2003) which states "any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled" (*i.e.*, any reconciliation of outlier payments will be based on the actual CCR from the relevant settled cost report). Further, as part of this "reconciliation process," the June 2003 Final Rule includes an adjustment for the time value of money which, as previously discussed, was implemented at MCPM, Ch. 3, § 20.1.2.6. The scope of the Board's authority is set by 42 C.F.R. § 405.1867 which limits the Board to compliance "with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator . . . ."[60] Finally, the Board is not bound, but must "afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."[61]

The Board finds that CMS did not act in an arbitrary and capricious manner nor did it abuse its discretion when setting the outlier threshold in 2003 or in calculating outlier payments in FY 2006. CMS issued the June 2003 Final Rule through notice and comment rulemaking. As part of the Final Rule, CMS determined that outlier payments should be subject to reconciliation, and announced that "***each hospital is on notice*** *as to our revised methodology* for determining cost-

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[56] *Id.* at 13; *Clarian Health West*, 878 F.3d at 358 (citing *Nat'l Mining Ass'n v. McCarthy*, 758 F.3d 243, 252 (D.C. Cir. 2014)).
[57] Medicare Contractor's FPP at 13.
[58] *Id.* at 14.
[59] 68 Fed. Reg. at 34502 (implementing the regulations at issue).
[60] 42 C.F.R. § 405.1867.
[61] *Id.*

to-charge ratios ***and*** *that outlier payments are* ***subject to possible reconciliation***."[62] The Secretary specified in the Preamble to the June 2003 Final Rule that she would issue additional program instructions on the outlier threshold that would trigger mandatory reconciliation.

> Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003.
>
> ***In the same program instruction***, *we will issue thresholds for fiscal intermediaries to reconcile outlier payments for other hospitals during FY 2003*.
>
> For cost reporting periods beginning during FY 2004, we are *considering* instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be ***plus or minus 10 percentage points*** from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000.[63]

Consistent with the preamble discussion, CMS issued PMIT A-03-058 on July 3, 2003 to provide guidance to Medicare Contractors on the reconciliation process and to finalize the 10 percent threshold discussed in the June 9, 2003 Final Rule. PMIT A-03-058 states, in pertinent part:

> [F]or discharges occurring in cost reporting periods beginning on or after October 1, 2003 for all other IPPS hospitals, fiscal intermediaries are to reconcile outlier payments at the time of cost report final settlement if:
>
> 1) Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and
>
> 2) Total outlier payments in that cost reporting period exceed $500,000.[64]

PMIT A-03-058 was later replaced with Transmittal 707 which incorporated PMIT A-03-58 (at MCPM, Ch.3, § 20.1.2.5) and added provisions to address the adjustment for the time value of money at MCPM, Ch. 3, § 20.1.2.6. The Providers in this appeal are disputing approximately $5,188,000 in outlier payments that were excluded from their cost reports due to CMS setting a 10 percent outlier threshold.[65] The Providers contend the 10 percent outlier threshold was not mandated until the issuance of PMIT A-03-058 on July 3, 2003 and, thus, is invalid because it

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[62] 68 Fed. Reg. at 34502 (emphasis added).
[63] *Id.* at 34503 (emphasis added).
[64] PMIT A-03-058.
[65] Providers' FPP at 2.

was not the product of notice and comment rulemaking.[66] The Providers further claim that CMS was arbitrary and capricious in establishing the 10 percent threshold.[67]

In the D.C. Circuit's decision in *Clarian*, the provider challenged the December 3, 2010 CMS guidance in the MCPM, Ch. 3 § 20.1.2.5 which mandated the same 10 percent outlier reconciliation threshold. The provider asserted that both the APA[68] and 42 U.S.C. §§ 1395hh(a)(1) and (b)(1) required the Secretary to promulgate the criteria for selecting hospitals for reconciliation by regulation after notice-and-comment rule making. Because the December 3, 2010 Manual instructions were not established in that manner, the provider claimed that both the instructions and the reconciliation taken pursuant to them were procedurally invalid. The D.C. Circuit concluded that "the [2010] Manual instructions embody a general statement of policy, not a legislative rule, setting forth HHS's enforcement priorities. . . . And they are not "rules" that must be issued through notice-and-comment rule making. . . . Nor are the instructions subject to the Medicare Act's independent notice-and-comment requirement because they do not establish or change a substantive legal standard."[69]

The D.C. Circuit continued, stating: "It cannot be seriously disputed that HHS's authority to reconcile outlier payments alters providers' legal rights. . . . But this change in providers' rights results from the Medicare Act and its implementing regulations—not the 2010 Manual instructions."[70] The D.C. Circuit found that:

> Together, the Act and the regulations establish the standard that governs hospitals' eligibility for outlier payments. . . . [T]hese statutory and regulatory provisions [42 U.S.C. § 1395ww(d)(5)(A)(ii), 42 C.F.R. §§ 412.80(a)(1), 412.84(i)(4)], of their own force, provide the agency with authority to engage in reconciliation for any outlier payment. Therefore these provisions establish the substantive legal standards governing provider reimbursement. The Manual instructions do not alter the applicable legal standards. . . . [T]he important point is that the agency maintains the same authority to reconcile any outlier payment that it had prior to the adoption of the Manual instructions. The instructions merely set forth an enforcement policy that determines when MACs will report hospitals for reconciliation. They do not change the legal standards that govern the hospitals, and they do not change the legal standards that govern the agency.[71]

The D.C. Circuit further highlighted that:

> [R]econciliation can be initiated in any situation in which CMS deems it appropriate, irrespective of whether the criteria in the

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[66] *Id.* at 9.
[67] *Id.* at 6.
[68] 5 U.S.C. § 553.
[69] *Clarian Health West LLC v. Hargan*, 878 F.3d 346, 349 (D.C. Cir. 2017).
[70] *Id.* at 355.
[71] *Id.* at 355-356.

> Manual instructions are met. . . . A hospital may pursue an action with the Board to challenge an agency decision to subject it to reconciliation without regard to whether it allegedly satisfied the criteria in the 2010 Manual instructions. The instructions thus did not alter or establish a substantive legal standard and the Medicare Act did not require HHS to promulgate the instructions by regulation.[72]

Accordingly, the D.C. Circuit found "the instructions constitute a general statement of policy setting forth the agency's enforcement priorities that binds neither CMS nor the Board. They are accordingly exempt from § 553's notice-and-comment requirement."[73]

The D.C. Circuit noted "the Manual instructions constitute a policy statement for the same reason that they do not create or amend a substantive legal standard—they have no binding legal effect."[74] The D.C. Circuit stated that "the Manual instructions 'merely explain[] how the agency will ***enforce*** a statute or regulation—in other words, how it will exercise its broad enforcement discretion. . . . Namely, they describe the way in which CMS, through its . . . [Medicare contractors], will implement the reconciliation authority from the 2003 rule."[75]

As in *Clarian*, the Providers in this appeal contend that the instructions of PMIT A-03-058 are invalid because CMS failed to comply with the APA's notice and comment requirements prior to issuing those instructions. However, the Board concurs with the D.C. Circuit's conclusion in *Clarian* that the 2010 Manual instruction (which restates the same outlier reconciliation procedure as PMIT A-03-058) embodies "a general statement of policy, not a legislative rule, setting forth HHS's enforcement priorities."[76] Further, the Board notes that, "[p]olicy statements do not establish binding norms. . . . And they are not `rules' that must be issued through notice-and-comment rule making. . . . Nor are the instructions subject to the Medicare Act's independent notice-and-comment requirement because they do not establish or change a substantive legal standard."[77] Thus, per *Clarian*, PMIT A-03-058, which was replaced with Transmittal 707, is a general statement of policy and is not subject to the APA or the Medicare Act's notice and comment rulemaking requirements. The Board rejects the Providers' argument that the 10 percent threshold is invalid because the Agency has never undertaken notice and comment rulemaking in connection with its adoption.[78] Further, the Board finds that the Providers' assertion, based upon *Catholic Health Initiatives*, that the 10 percent threshold trigger should be viewed as a legislative rule also fails as the D.C. Circuit in *Clarian* concluded that the Manual instruction embodies a general statement of policy *not* a legislative rule.

The Providers contend, in passing, that the Secretary: (1) "acted in an arbitrary and capricious manner and abused her discretion when setting the outlier thresholds and calculating outlier payments for FY 2006"; (2) "failed to consider relevant factors and data which should have been taken into account when setting the criteria [*i.e.*, declining cost to charge ratios]"; (3) "failed to

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[72] *Id.* at 356.
[73] *Id.* at 357.
[74] *Id.*
[75] *Id.* at 358 (citation omitted and emphasis added).
[76] *Id.* at 349.
[77] *Id.*
[78] Providers' FPP at 11.

consider alternative methodologies when establishing the outlier thresholds [use of the cost methodology rather than the charge methodology]"; and, (4) "failed to demonstrate a reasonable connection between the threshold and the factors considered [failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process]."[79] However, the Providers failed to provide any factual or legal basis to support these blanket assertions. In fact, these contentions are ***not*** even mentioned again in the Providers' Final Position Paper. Therefore, the Board finds that the Providers provided no factual or legal support for these arguments and that *they were abandoned by the Providers*.

The 2003 Final Rule received 582 timely public comments regarding the March 5, 2003 Outlier Proposed Rule. Particularly relevant to this appeal, some commenters requested that parameters be established to identify what hospitals would be subject to reconciliation:

> *Comment*: Some commenters suggested that we clarify how reconciliation will be implemented and only reconcile outlier payments to those providers whose cost-to-charge ratios increased or decreased outside of certain parameters. The commenters suggested that we reconcile outlier payments only for those hospitals that would otherwise receive substantial outlier overpayments or underpayments (for example, where the cost-to-charge ratio increased or decreased by 15 percent). Limiting any reconciliation to those hospitals would have the desired impact of focusing the attention of CMS on those hospitals that deserve additional scrutiny without placing such a burden on all hospitals.[80]

CMS agreed with this idea, stating in the preamble to the 2003 Final Rule that, "[t]herefore, we agree that any reconciliation of outlier payments should be done on a limited basis" and "[f]or cost reporting periods beginning during FY 2004, we are considering instructing fiscal intermediaries to conduct reconciliation[s] for hospitals whose actual cost-to-charge ratios are found to be plus or minus 10 percentage points from the cost-to-charge ratio used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000."[81] The Board finds that the 10 percent outlier threshold outlined in the 2003 Final Rule and finalized in PMIT A-03-058 (which was replaced by Transmittal 707) was a logical outgrowth of the commenters' request (as well as CMS' agreement with the request) to establish thresholds. Therefore, the 10 percent outlier threshold was not in violation of the APA or the FOIA.

Further, because the threshold procedures are rationally related to the goals of outlier reconciliation, the Board rejects the Providers' argument that the Secretary acted in an arbitrary and capricious manner when setting the 10 percent outlier threshold. Similarly, the Board finds the Providers' argument, that the Secretary acted in an arbitrary and capricious manner when calculating outlier payments for FY 2006, unpersuasive. The CCR used to calculate the Providers' outlier payments varied by more than 10 percentage points from the actual CCR calculated by the Medicare Contractor in 2006, and the total outlier payments exceeded

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[79] *Id.* at 6.
[80] 68 Fed. Reg. at 34503.
[81] *Id.*

$500,000. Therefore, the Board finds that the Medicare Contractor properly determined that reconciliation was appropriate.[82]

In addition, the Providers contend that there is no indication that CMS has ever reevaluated the 10 percent threshold and that the 10 percent criterion is based upon outdated assumptions, such as the existence of inflation in outlier payments.[83] CMS stated in the 2003 Final Rule that "thresholds would be reevaluated annually and, if necessary, modified each year."[84] The Providers bear the burden of producing evidence to support their claims, yet there is nothing in the record to indicate that the thresholds have not been reevaluated by CMS each year. Similarly, the Providers contend that their CCR "is in error and needs to be revised to correct certain errors made and contained in the cost report."[85] However, the Providers do not identify any alleged errors or state what needs to be revised in the CCR. Accordingly, the Board finds that the Providers have not provided any factual or legal support for these contentions.

B. ISSUE NOT PART OF THIS OPTIONAL GROUP APPEAL AND OTHERWISE ABANDONED

The group issue statement filed for the optional group on September 29, 2014 reads as follows, *in its entirety*:

> **Statement of Issue**
>
> Whether the Medicare reimbursement the Provider received for its cost outlier cases was properly determined and in accordance with applicable Medicare statues and regulations? Did CMS set the cost outlier threshold appropriately? Was CMS arbitrary and capricious in establishing a 10% threshold in 2003 and utilizing the same 10% threshold in 2006 to determine if a Provider would be subjected to outlier reconciliation adjustments?
>
> **Statement of the Legal Basis**
>
> The Provider contends the Secretary's final determination of outlier payments for the fiscal years 2004, 2005, [*sic*] and 2006 was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when setting the outlier thresholds and calculating outlier payments for federal fiscal years 2004, 2005 [*sic*]

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[82] Indeed, focusing on the 10 percent threshold may be a red herring. A plain reading of the regulation itself provides CMS with discretion on whether to conduct a reconciliation and does not itself impose any threshold (rather the 10 percent threshold is specified in the MCPM). Moreover, the *supra* regulatory discussion on the preamble to the June 2003 Final Rule, PMI Transmittal A-03-058, and the MCPM make clear that the Agency has consistently maintained that the Medicare Contactor still has certain discretion to conduct reconciliation when the 10 percent threshold has not been met.
[83] Providers' FPP at 12.
[84] 68 Fed. Reg. at 34503.
[85] Providers' FPP at 13.

and 2006. The Secretary failed to consider relevant factors and data which should have been taken into account when setting the criteria, failed to consider alternative methodologies when establishing the outlier thresholds and failed to demonstrate a reasonable connection between the threshold and the factors considered. Among other things, the Secretary failed to consider relevant data which showed that the rate of increase in hospital costs per discharge was trending downward and that the relationship of hospital costs to hospital charges was changing. The Secretary thus failed to take into account the stablished pattern of declining cost-to-charge ratios, which play a significant part in the calculation of outlier payments, despite this problem being repeatedly point out in comments and despite proposed methods to account for this phenomenon and to more accurately estimate outlier payments so that thresholds could be set more accurately. Further, the Secretary failed to consider use of the "cost methodology," rather than the "charge methodology," in setting outlier thresholds, despite the fact that the cost methodology had been more accurate in predicting outlier payments in prior years. Finally, the Secretary failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process. These deficiencies in the Sectary's methodology were identified in the rulemaking comments submitted for the fiscal years at issue. By ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled. As a result of these arbitrary and capricious actions, the thresholds were set too high, the resulting amount of outlier payments each year fell short of the percentage required by the Medicare Act and hospital did not receive the amount of outlier payments that Congress intended.

The 10% threshold was not mentioned in the proposed rule dated March 5, 2003. Instead, the first mention of the possibility of employing a 10% threshold was in the *final rule* dated June 9, 2003. This final rule did not provide the public with an opportunity to comment on the agency's consideration of a 10% threshold. Accordingly, the 10% threshold was not the product of notice and comment rulemaking. The 10% threshold may also violate the public disclosure provisions of the Freedom of Information Act (FOIA).

The 10% criterion for identifying hospitals subject to reconciliation was initially implemented for FY 2003 and FY 2004. The Federal Register notice dated June 9, 2003 stated that the 10% threshold would be "*reevaluated annually and, if necessary, modified each year*." 68 Fed. Reg. 34494, 34503. See also PM A-03-058, noting that the 10% criteria "*will be evaluated periodically to assess whether [it] should be revised*." *Id.* at p. 4. There is no indication that CMS has ever engaged in such a reevaluation.

> The Provider also contends that the Medicare inpatient cost to charge ratio is in error and needs to be revised to correct errors made and contained in the cost report. These corrections will have an impact on the outlier amount due the Provider that was determined in the reconciliation process.[86]

Thus, the group issue statement focuses on 3 areas, namely the fixed loss threshold for outlier payments during 2006, the validity of CMS' establishment of the 10 percent threshold for outlier reconciliation process, and potential errors in the Medicare inpatient cost to charge ratio for 2006. The Board further notes that the issue statement improperly refers to fiscal years 2004 and 2005 which are not at issue in the optional group which *only* encompasses 2006.

However, optional group appeals may only have *one* issue as explained in 42 C.F.R. § 405.1837(b)(2)(i):

> Two or more providers *not under common ownership or control* may bring a group appeal before the Board under this section, if the providers wish to appeal to the Board *a specific matter at issue that involves* ***a question*** *of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers*. Alternatively, any provider may appeal to the Board any issues in a single provider appeal brought under § 405.1835 of this subpart.[87]

Further, providers in a group may not add issues to their group as explained in 42 C.F.R. § 405.1837(f)(1):

> After the date of receipt by the Board of a group appeal hearing request . . ., a provider may not add other questions of fact or law to the appeal, regardless of whether the question is common to other members of the appeal . . . .

Similarly, Board Rule 4.5 (Mar. 1, 2013, July 1, 2015) specifies that "A Provider may not appeal an issue from a final determination in more than one appeal."[88]

Here, the Providers appear to have ***improperly*** attempted to pursue additional issues outside of the outlier reconciliation threshold issue as part of this group even though they may have only one in the group. One of these other issues (the fixed loss threshold issue) was a prohibited

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[86] (Emphasis in original.)

[87] (Emphasis added.) *See also* 42 C.F.R. § 405.1837(f)(2) (stating that "[t]he Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal.").

[88] *See Baptist Memorial Hospital-Golden Triangle v. Sebelius*, 566 F.3d 226 (D.C. Cir. 2009) ("*Baptist*"). In *Baptist*, the D.C. Circuit found the following: "Notwithstanding the clear directions in the [PRRB] Instructions, the hospitals *gamely* argue that they did not need to follow the Instructions to reinstate a previously **dismissed** appeal. . . . The hospitals cannot so easily evade the plain meaning of the Instructions. The relevant reinstatement provision quite clearly explains how to reinstate appeals for failure to file a timely position paper and lists certain requirements for doing so—including that the party 'explain in detail' its reason for non-compliance." (Emphasis added.)

duplicate in that the Providers pursued that ***same*** issue for the ***same*** year as part of a separate optional group (Case No. 14-4409G) *that was **filed on the same day** as the instant optional group appeal (September 29, 2019)*.[89] Similarly, another issue involving the time value of money assessed on their outlier reconciliation overpayments[90] was improperly raised *for the first time* as part of the Providers' final position paper.[91] However, it is clear that the Providers

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[89] The statement of the legal basis in Case No. 14-4409G is virtually identical to the 1st paragraph of that instant case (as quoted above, differing primarily by the reference in error to 2004 when 2006 is the year at issue in Case No. 14-4409G):

> **Statement of the Legal Basis**
>
> The Provider contends the Secretary's final determination of outlier payments for the fiscal year 2004 [*sic* 2006] was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when setting the outlier threshold and calculating outlier payments for federal fiscal year 2004 [*sic* 2006]. The Secretary failed to consider relevant factors and data which should have been taken into account when setting the criteria, failed to consider alternative methodologies when establishing the outlier thresholds and failed to demonstrate a reasonable connection between the threshold and the factors considered. Among other things, the Secretary failed to consider relevant data which showed that the rate of increase in hospital costs per discharge was trending downward and that the relationship of hospital costs to hospital charges was changing. The Secretary thus failed to take into account the stablished pattern of declining cost-to-charge ratios, which play a significant part in the calculation of outlier payments, despite this problem being repeatedly point out in comments and despite proposed methods to account for this phenomenon and to more accurately estimate outlier payments so that thresholds could be set more accurately. Further, the Secretary failed to consider use of the "cost methodology," rather than the "charge methodology," in setting outlier thresholds, despite the fact that the cost methodology had been more accurate in predicting outlier payments in prior years. Finally, the Secretary failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process. These deficiencies in the Sectary's methodology were identified in the rulemaking comments. By ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled. As a result of these arbitrary and capricious actions, the threshold was set too high, the resulting amount of outlier payments fell short of the percentage required by the Medicare Act and hospital did not receive the amount of outlier payments that Congress intended.

After filing their final position paper in Case No. 14-4409G, the Providers withdrew their appeal on July 23, 2019. The Providers are prohibited from pursuing this issue in a separate duplicate appeal in the instant case by 42 C.F.R. §§ 405.1837(a), (b)(2) and (f)(2) and Board Rules 4.5 (2013, 2015) and 4.6 (2018). The Board further notes that, even if the instant group were not a prohibited duplicate appeal, the Board would need to resolve jurisdictional issues. This is highlighted by the participant Deaconess Medical Center (Prov. No. 50-0044). The documentation included in the Schedule of Providers for this participant shows it transferred to Case No 14-4410G from Case No. 13-0449; however, the appeal request in Case No. 13-0449 does *not* appear to include this fixed loss threshold issue. If the issue was not common to two providers that were used to establish the optional group, then it could never have been considered to be part of the case and it could *not* have been considered for potential bifurcation under 42 C.F.R. § 405.1837(f)(2)(ii).

[90] Providers' FPP at 13.

[91] The time value of money issue is a separate issue from outlier reconciliation threshold (and the resulting outlier reimbursement) and, to that end, challenges a separate regulatory provision. Notwithstanding the content requirements for appeal requests at 42 C.F.R. §§ 405.1835(b) and 405.1837(c) and Board Rules 7, 8, 13 (Mar. 2013), the time value of money issue is *neither* raised in the Providers' group issue statement *nor* in the statement of the legal basis, but rather was *improperly* raised *for the first time* in the Providers' June 6, 2019 Final Position Paper. Providers' FPP at 13. *See also* Board Rule 13 (applying Board Rule 7 and 8 to group appeals); Board Rule 8.1 (2013) (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7."). As such, the Board may ***not*** consider the time value of money issue as it is outside of the scope of the Providers' optional group appeal and may ***not*** be later added to the group appeal pursuant to § 405.1837(f)(1). Moreover, even if true, the Board would need to confirm that the final Schedule of Providers for this

abandoned these other potential additional issues when they submitted their request for record hearing representing that "[t]his case involves *only the legal issue of* ***its Outlier Reconciliation***, namely, whether the Providers received reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs."[92] The issue statement in the record hearing request is further clarified in the Stipulation of Facts *attached to that request* that the Providers entered into with the Medicare Contractor *wherein they agreed*:

> The issue in this appeal is whether CMS was arbitrary and capricious in establishing a ten percent (10%) threshold in 2003 and whether CMS was arbitrary and capricious in using the same ten percent (10%) threshold in 2006 to determine whether Providers would be subject to outlier reconciliation adjustments.[93]

Again, as a group may only contain one issue, the Board finds the Stipulations to be conclusive. Accordingly, any and all other issues which the Providers may have reference in earlier filings have been effectively abandoned, and would have been otherwise dismissed as improper.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor was not arbitrary and capricious in using the ten percent threshold in 2006 to determine whether the Providers would be subject to outlier reconciliation adjustments.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, C.P.A
Robert A. Evarts, Esq.
Kevin D. Smith, C.P.A.
Ratina Kelly, C.P.A.

FOR THE BOARD:

9/26/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

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case documents that the $50,000 minimum amount in controversy has been *separately* met for time value of money issue as required by 42 C.F.R. § 405.1839(b). Regardless, even if it had been included in the group appeal request, the Board would still have to address the jurisdictional question of whether both of the participants in the group appeal included this issue both as part of the individual appeals from which they transferred as well as the transfer request itself.

[92] (Emphasis added.)

[93] Stipulations at ¶ 1.

Attachment A

MODEL FORM G : SCHEDULE OF PROVIDERS IN GROUP

Group Name: QRS 2006 Outlier Reconciliation Group — Page No. 1 of 1

Representative: Quality Reimbursement Services, Inc. — Date Prepared: November 6, 2015

Case No.: 14-4410G — Issue: Outlier Payments-Fixed Loss Threshold, Operating Cost to Charge Ratio and Outlier Reconciliation Adjustments

					A	B	C	D	E	F	G	H
	Provider No.	Provider Name City, County, State	FYE	MAC	Date of Final Determ	Date of Hearing Request/ Add issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s)	Date of Direct Add/ Transfer(s) to Group	NOR
1	34-0091	The Moses H. Cone Memorial Hospital Greensboro, Guilford, NC	09/30/2006	NGS	10/16/2012	04/12/2013	178	20	$ 2,993,000	13-1629	09/29/2014	08/28/2013
2	50-0044	Deaconess Medical Center Spokane, Spokane, WA	12/31/2006	WPS	08/14/2012	01/07/2013[1]	146	28,32	$ 2,195,000	13-0449	09/29/2014	06/25/2014
						Total Estimated Reimbursement			$ 5,188,000			

[1]In lieu of the proof of delivery, QRS has provided the Acknowledgement of Critical Due Dates showing the date the appeal was received by the Board.